State of Utah
DCC – FORM 883 H
HEAT Program
Rev. 04-05

RELEASE OF MEDICAL INFORMATION FORM
H.E.A.T. Utility Assistance Program
Disability Verification

PURPOSE: The patient below has applied for HEAT benefits and could be eligible for an additional $50.00 credit if he/she meets the criteria for a qualifying disability. The HEAT program defines disability as ***"the inability to engage in any substantial gainful employment by reason of a medically determinable physical or mental impairment which can be expected to last or has lasted for a continuous period of at least six (6) months." If patient is a child, disregard "employment" issues.***

Part A: Patient (HEAT Applicant): *Please Print*

I _____ authorize my physician as designated below in Part B to release to the State of Utah HEAT Program (324 S. State Street, Ste. 500, SLC, UT, 84111) any information regarding my current physical condition as it relates to disability status.

_____ _____
Signature of Patient or Designee Date

Part B: Physician:

I certify that _____ is currently under my care, and at this time meets the disabled criteria as defined and understood in the HEAT disability definition stated above.

_____ _____
Name of Physician Signature of Physician

_____ _____
Office Telephone Number Date

CONFIDENTIALITY STATEMENT:
All HEAT workers have signed a confidentiality agreement with the State of Utah and are familiar with the laws regarding the confidentiality and transport of medical information.

If you have any questions or concerns, you may call me at:

HEAT Worker Name _____ HEAT Office Telephone Number_____